Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PHYSICIAN MGMT SVCS DBA INJURY 1 TRTMT CTR
5931 DESCO DR
DALLAS TX 75225

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4-13-0631-01

MFDR Date Received
NOVEMBER 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance company denied the claims stating 'payment reduced for absence of precertification. The evaluation/treatment rendered CPT code 90801 does not require preauthorization per rule 134.600."

Amount in Dispute: $219.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the disputed charges and determined pursuant to Rule 134.600(p) which states 'Non-emergency health care requiring preauthorization includes (12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier'. Review of the ODG under the diagnosis utilized by the provider which is 847.0-Sprain of neck, 847.1-Sprain Thoracic and 920-Contusion face/scalp/neck indicates that psychological screening is only recommended as an option prior to surgery. Review of the Neck and Upper Back chapter there is no recommendation for psychological testing/screening. Further review of the claim did not find that the injured employee was being referred for chronic pain management or work hardening where there would be a psychological screen performed to substantiate the necessity for such programs."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2012	90801	$219.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600 sets out the procedures for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the treatment guidelines for disability management.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197 – Payment denied/reduced for absence of precertification/preauthorization.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - Per Rule 134.600(P)(12) carrier is not liable for treatment and/or services provided in excess of the Divisions Treatment Guidelines unless in an emergency or pre-authorization rules.

Issues

1. Was the requestor required to obtain preauthorization for CPT code 90801?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   Per 28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

   The requestor seeks reimbursement for CPT code 90801 defined as "Psychiatric diagnostic interview examination" rendered on August 6, 2012.
2. Review of the Official Disability Guidelines (ODG) under the diagnosis utilized by the provider indicates that psychological screening is only recommended as an option prior to surgery. Review of the Neck and Upper Back chapter finds there is no recommendation for psychological testing/screening, as a result the disputed service is subject to preauthorization pursuant to 28 Texas Administrative Code §134.600 (p)(12) and 28 Texas Administrative Code §137.100.
3. Review of the submitted documentation finds that the requestor did not submit documentation to support that preauthorization was obtained as required by 28 Texas Administrative Code §134.600 (p)(12) and 28 Texas Administrative Code §137.100. As a result, reimbursement cannot be recommended for CPT code 90801.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.